AHIMA Member Comments on ONC Proposed Interoperability Standards Measurement Framework

**John Odden’s Comments**

**From:** John Odden [mailto:john.odden@gmail.com]   
**Sent:** Thursday, May 11, 2017 6:07 PM  
**To:** Diana Warner  
**Subject:** Re: Comments on ONC Proposed Interoperability Measurement Framework

Hi Diana:

After you skim my comments, I'd value your suggestion as to whether I prioritize joining the 3 AHIMA Task Force calls.

1) The selection of "health IT developers and exchange services" as the most reliable data holders is unwise.  This request only continues the drive of those parties to create various added layers of fees and memberships to further the "data holding" mission they perceive the federal government to be tasking them to fulfill.  Yes the added layers of fees and memberships sought by health IT developers and exchange services only defer and suppress standards implementation and use.  It is not at all unusual to find a single provider asked to pay $1,000, or more, each month to join a "preferred exchange service," or to ask their Health IT developer to activate some "preferred standard."

2) Within the domains of accountable and value-based care, providers are using the health IT systems (often Certified for Meaningful Use) and adjuncts of those systems to meet the needs for care coordination.  This means that exchange-based standards and services are increasingly not a helpful point of measure.  In fact, there is growing voice of providers that exchanged-based information resources are too often a distraction from essential point of care workflow, not bringing value.

3) "Variability of standard implementation" reveals that too many critical standards developments efforts were left critically dependent on "paid volunteers" from health IT developers with strong profit incentives.  At a time when many of the nation's best implementers may say they "always have to break standard" to get to go-live, the issue is clear.  It is less clear if the critical standards can be remediated, or not.

4) Objective 1 seems designed to further the health IT developer / exchange network add-on subscription and membership programs.  Given the loss of interest fostered by the costs of these add-on programs, positioning non-provider revenue-seeking entities as gatekeepers may actually discourage adoption.

5) Objective 2 seems naive at a time with (a) feasibility of target workflow and (b) new unplanned costs imposed will drive behavior.  Perhaps look to measuring ancillary (non-claims) data cohorts related to accountable and value-based care?  Suggestion - deidentify the ancillary data cohorts (continuity of care documents, transition of care plans, etc) and have independently hired assessors measure the standards-relevant content built-in to actual patient cases.  Correlate with diagnoses and treatments to understand necessity and efficacy.

6) As one pathway to acquire useful insights, please consider: there are numerous NQF-endorsed standards (clinical quality standards) here <http://www.qualityforum.org/Measuring_Performance/Measuring_Performance.aspx>  Many providers report that health IT developer products to analyze and report on these standards must have the feature "edit reported Total Per Provider to correct value" in order to be usable.  Some deployments of solutions supporting all these standards find "no measures from NQF deployable here."  Methods and frameworks durable to support real progress in the daily working lives of providers could make a real difference, and are sorely needed.

Diana, I'm not on any funded pursuit here, just sharing what I've seen and heard to try and help.  What might make sense for a next step?

Thanks,

John

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**Marjorie Greenberg’s comments:**

**From:** Marjorie Greenberg [mailto:marjoriesg66@gmail.com]   
**Sent:** Monday, June 05, 2017 11:53 AM  
**To:** Diana Warner  
**Cc:** Anna Orlova; Barbara.Rudolph@chsra.wisc.edu; Chris Guerrero (Chris.Guerrero@dshs.state.tx.us); Genny Luensman (CDC/NIOSH/DRDS); Harold Lehmann (lehmann@jhmi.edu); Hetty Khan (CDC/OPHSS/NCHS); Jack Corley (corleyjh@me.com); Jaleann M Matos-McClurg; Jennifer Stone (Jstone0330@gmail.com); Joanna Jiang (joanna.jiang@ahrq.gov); John Odden (john.odden@gmail.com); Kim Baldwin-Stried Reich; Lisa Lang (NIH/NLM); Martin LaVenture (martin.laventure@state.mn.us); Michael Hill (hillrm831@gmail.com); Michelle Meigs; Michelle Williamson; Nikolay Lipskiy; Robert Aseltine (aseltine@uchc.edu); Robert Davis (rdavis@nahdo.org); Susan Salkowitz (salkowit@mac.com); Todd Watkins (Todd\_Watkins@stchome.com); Vicki Hohner (v.hohner@comcast.net); Walter Suarez (walter.g.suarez@kp.org)  
**Subject:** Re: Comments on ONC Proposed Interoperability Measurement Framework

Thank you for the opportunity to review and comment on the ONC Proposed Interoperability Measurement Framework.  The document provides a good description of the challenges, as well as the importance, of measuring interoperability and, specifically, standards implementation.

In the current environment, voluntary reporting, either through surveys or otherwise, is probably the most realistic approach, although it will result in less than complete data. Working closely with industry partners in designing and implementing annual surveys may be the best approach, although it will have limitations in response rates and bias.

ONC might also consider partnering with industry on some qualitative studies that identify whether and how entities actually are exchanging specific information and are able to use that information for business and clinical purposes.  These studies will help identify impediments and successful strategies to resolve these impediments and document the benefits of interoperability.

Wherever stakeholders are identified, public health entities should be included, both for collaboration and for data collection.

I hope that these comments are useful.

Best wishes,

Marjorie

**Harold Lehman’s comments**

**From:** Harold Lehmann [mailto:lehmann@jhmi.edu]   
**Sent:** Monday, June 05, 2017 12:52 PM  
**To:** Diana Warner  
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Just three comments:

Re measures: "volumes" of use should be reported in context of some denominator. I suppose a meaningful denominator would be, "# potential transactions", although I don't know how practicable such a # is to articulate.

The measures focus solely on generation of data, but not on receipt. I am not sure that successful receipt can be quantified, but if the is voluntary reporting, than it is reasonable to ask for a subjective assessment of "degree of successful ingestion of data sent", where "successful" includes both receipt and semantics (i.e., received as intended).

Overall, however, the nature of "standards" is never defined. It would be helpful to clarify the classes of standards intended.

Harold

**Susan Salkowitz comments**

**From:** Susan Salkowitz [mailto:salkowit@mac.com]   
**Sent:** Monday, June 05, 2017 1:20 PM  
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**Subject:** Re: Comments on ONC Proposed Interoperability Measurement Framework

Hi All:

I endorse the previous comments and ad the following:

What a daunting task in the face of uncertainty of HHS budgets, focus of new ONC leadership and the respective roles of government and the private sector.

If public reporting is implemented and the reporting is voluntary, what methods would be used to determine the completeness and accuracy of the reported items. This would presuppose at least some agreement on definitions.

Given the administration’s wish to privatize many activities, perhaps enlisting the vendors and some of the large health organizations would be a preferred avenue but as Marjorie suggests, how would public health have a real seat at the table? Regards, Sue

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